

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041699</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Heritage Manor-Springfield</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>900 N RUTLEDGE</u> <u>Springfield</u> <u>61701</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>SANGAMON</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(217) 789-0930</u> Fax # ()		(Type or Print Name) <u>CRAIG L. ATER</u>	
IDPA ID Number: <u>371359387001</u>		(Title) <u>Senior Vice President -- Finance</u>	
Date of Initial License for Current Owners: <u>1996</u>		Paid Preparer (Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> GOVERNMENTAL		(Firm Name & Address) _____	
<input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Individual <input type="checkbox"/> State		(Telephone) <u>(309) 823-7135</u> Fax # ()	
<input type="checkbox"/> Trust <input type="checkbox"/> Partnership <input type="checkbox"/> County		MAIL TO: OFFICE OF HEALTH FINANCE	
IRS Exemption Code _____ <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Other _____		ILLINOIS DEPARTMENT OF PUBLIC AID	
Limited Liability Co.		201 S. Grand Avenue East	
Trust		Springfield, IL 62763-0001	
Other _____		Phone # (217) 782-1630	
In the event there are further questions about this report, please contact:			
Name: <u>CRAIG L. ATER</u>			
Telephone Number: <u>()</u>			

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Facility Name & ID Number Heritage Manor-Springfield# 0041699 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>176</u>	Skilled (SNF)	<u>176</u>	<u>64,240</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4		Intermediate/DD			4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6		ICF/DD 16 or Less			6
7	<u>176</u>	TOTALS	<u>176</u>	<u>64,240</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>32,856</u>	<u>16,165</u>	<u>8,143</u>	<u>57,164</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,856</u>	<u>16,165</u>	<u>8,143</u>	<u>57,164</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.99%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1996

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date 1996 NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter numberof beds certified _____ and days of care provided 8,143

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Heritage Manor-Springfield

0041699

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	361,538	19,573		381,111		381,111	6,030	387,141			1
2	Food Purchase		165,152		165,152		165,152	(857)	164,295			2
3	Housekeeping	154,336	31,507		185,843		185,843		185,843			3
4	Laundry	103,593	25,633		129,226		129,226		129,226			4
5	Heat and Other Utilities			135,041	135,041		135,041	1,876	136,917			5
6	Maintenance	167,027	62,642	39,907	269,576		269,576	16,228	285,804			6
7	Other (specify):*											7
8	TOTAL General Services	786,494	304,507	174,948	1,265,949		1,265,949	23,277	1,289,226			8
	B. Health Care and Programs											
9	Medical Director			16,900	16,900		16,900		16,900			9
10	Nursing and Medical Records	2,703,370	175,562	20,652	2,899,584		2,899,584		2,899,584			10
10a	Therapy		568,879	450,289	1,019,168	(745,256)	273,912	289,736	563,648			10a
11	Activities	100,065	5,879		105,944		105,944		105,944			11
12	Social Services	100,366		1,650	102,016		102,016		102,016			12
13	Nurse Aide Training							3,353	3,353			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,903,801	750,320	489,491	4,143,612	(745,256)	3,398,356	293,089	3,691,445			16
	C. General Administration											
17	Administrative	69,064			69,064		69,064	155,849	224,913			17
18	Directors Fees							8,272	8,272			18
19	Professional Services			357,817	357,817		357,817	(334,245)	23,572			19
20	Dues, Fees, Subscriptions & Promotions			120,465	120,465	(96,360)	24,105	(1,358)	22,747			20
21	Clerical & General Office Expenses	272,508	29,551	36,820	338,879		338,879	327,810	666,689			21
22	Employee Benefits & Payroll Taxes			641,041	641,041		641,041	42,865	683,906			22
23	Inservice Training & Education			653	653		653	1,346	1,999			23
24	Travel and Seminar			5,558	5,558		5,558	(3,559)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			75,099	75,099		75,099	3,157	78,256			26
27	Other (specify):*			47,577	47,577		47,577	(47,577)				27
28	TOTAL General Administration	341,572	29,551	1,285,030	1,656,153	(96,360)	1,559,793	152,560	1,712,353			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,031,867	1,084,378	1,949,469	7,065,714	(841,616)	6,224,098	468,926	6,693,024			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number Heritage Manor-Springfield

#0041699

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			295,944	295,944		295,944	15,400	311,344			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,045	155,045		155,045	(3,838)	151,207			32
33	Real Estate Taxes			110,338	110,338		110,338		110,338			33
34	Rent-Facility & Grounds							11,827	11,827			34
35	Rent-Equipment & Vehicles			118	118		118	23,394	23,512			35
36	Other (specify):*											36
37	TOTAL Ownership			561,445	561,445		561,445	46,783	608,228			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					745,256	745,256		745,256			39
40	Barber and Beauty Shops		76	889	965		965		965			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					96,360	96,360		96,360			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		76	889	965	841,616	842,581		842,581			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,031,867	1,084,454	2,511,803	7,628,124		7,628,124	515,709	8,143,833			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor-Springfield

0041699

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(4,224)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(857)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(940)	20		17
18	Fines and Penalties				18
19	Entertainment	(14,034)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(740)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,577)	27		24
25	Fund Raising, Advertising and Promotional	(6,832)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,204)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	590,913		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 590,913		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 515,709		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Springfield

ID# 0041699

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$	0	0
2		0	0
3		0	0
4		0	0
5		0	35
6		0	34
7		0	
8		0	
9		0	30
10			32
11		0	
12		0	
13		(857)	2
14		0	32
15		0	33
16		0	24
17		(940)	20
18		0	
19			24
20		0	27
21		0	
22		(740)	19
23		0	
24		(47,577)	27
25		(6,832)	20
26		0	0
27		0	0
28		0	0
29		0	0
30		0	0
31		0	0
32			
33		0	33
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49	Total	(56,946)	

Summary A

12/31/2002

12/31/2002

[illegible]

Summary B

12/31/2002

12/31/2002

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organization	427,098	GreenTree Therapy	100.00%	561,095	133,997	2
3	V								3
4	V	19	Adjustment for Related Organization	349,078	Heritage Enterprises, Inc.	100.00%		(349,078)	4
5	V								5
6	V	10a	Adjustment for Related Organization	574,353	GreenTree Pharmacy	100.00%	730,092	155,739	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,350,529			\$ 1,291,187	\$ * (59,342)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Springfield# 0041699Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 6,030	\$ 6,030
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				1,876	1,876
20	V	6 Maintenance				16,228	16,228
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				3,353	3,353
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				155,849	155,849
30	V	18 Directors Fees				8,272	8,272
31	V	19 Professional Services				15,573	15,573
32	V	20 Fees, Subscription, Promotions				6,414	6,414
33	V	21 Clerical & General Office Expenses				327,810	327,810
34	V	22 Employee Benefits & Payroll Taxes				42,865	42,865
35	V	23 Inservice Training & Education				1,346	1,346
36	V	24 Travel and Seminar				10,475	10,475
37	V	25 Other Admin. Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				3,157	3,157
39	Total		\$			\$ 599,248	\$ * 599,248

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Springfield# 0041699Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	27 Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V	30 Depreciation				15,400	15,400
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				386	386
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				11,827	11,827
21	V	35 Rent-Equipment & Vehicles				23,394	23,394
22	V	36 Other				0	
23	V	38 Medically Nec Transportation				0	
24	V	39 Ancillary Service Centers				0	
25	V	40 Barber and Beauty Shops				0	
26	V	41 Coffee and Gift Shops				0	
27	V	42 Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 51,007	\$ * 51,007

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises, Inc.			0.50					\$ 164,121	line 17/18	1
2	Memorial Health Ventures			0.50							2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 164,121		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Springfield# 0041699

Report Period Beginning:

1/01/2002Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Beds	2,401	24	\$ 82,266	\$ 82,266	176	\$ 6,030	1
2	2 Food Purchase	Beds	2,401	24	0	0	176	0	2
3	3 Housekeeping	Beds	2,401	24	0	0	176	0	3
4	4 Laundry	Beds	2,401	24	0	0	176	0	4
5	5 Heat & Other Utilities	Beds	2,401	24	25,593	0	176	1,876	5
6	6 Maintenance	Beds	2,401	24	221,381	58,785	176	16,228	6
7	7 Other	Beds	2,401	24	0	0	176	0	7
8	9 Medical Director	Beds	2,401	24	0	0	176	0	8
9	10 Nursing & Medical Records	Beds	2,401	24	0	0	176	0	9
10	11 Activities	Beds	2,401	24	0	0	176	0	10
11	12 Social Service	Beds	2,401	24	0	0	176	0	11
12	13 Nurse Aide Training	Beds	2,401	24	45,737	39,267	176	3,353	12
13	14 Program Transportation	Beds	2,401	24	0	0	176	0	13
14	15 Other	Beds	2,401	24	0	0	176	0	14
15	17 Administrative	Beds	2,401	24	2,126,096	2,126,096	176	155,849	15
16	18 Directors Fees	Beds	2,401	24	112,849	0	176	8,272	16
17	19 Professional Services	Beds	2,401	24	212,454	0	176	15,573	17
18	20 Fees, Subscription, Promotions	Beds	2,401	24	87,500	0	176	6,414	18
19	21 Clerical & General Office Expense	Beds	2,401	24	4,472,002	4,183,145	176	327,810	19
20	22 Employee Benefits & Payroll Tax	Beds	2,401	24	584,769	0	176	42,865	20
21	23 Inservice Training & Education	Beds	2,401	24	18,362	0	176	1,346	21
22	24 Travel and Seminar	Beds	2,401	24	142,902	0	176	10,475	22
23	25 Other Admin. Staff Transportation	Beds	2,401	24	0	0	176	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,401	24	43,070	0	176	3,157	24
25	TOTALS				\$ 8,174,981	\$ 6,489,559		\$ 599,248	25

Facility Name & ID Number Heritage Manor-Springfield# 0041699

Report Period Beginning:

1/01/2002Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27 Other	Beds	2,401	24	\$	\$	176	\$	1
2	30 Depreciation	Beds	2,401	24	210,090		176	15,400	2
3	31 Amortization of Pre-Op & Org	Beds	2,401	24			176		3
4	32 Interest	Beds	2,401	24	5,270		176	386	4
5	33 Real Estate Taxes	Beds	2,401	24			176		5
6	34 Rent-Facility & Grounds	Beds	2,401	24	161,349		176	11,827	6
7	35 Rent-Equipment & Vehicles	Beds	2,401	24	319,142		176	23,394	7
8	36 Other	Beds	2,401	24			176		8
9	38 Medically Nec Transportation	Beds	2,401	24			176		9
10	39 Ancillary Service Centers	Beds	2,401	24			176		10
11	40 Barber and Beauty Shops	Beds	2,401	24			176		11
12	41 Coffee and Gift Shops	Beds	2,401	24			176		12
13	42 Other	Beds	2,401	24			176		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 695,851	\$		\$ 51,007	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	Bank of Springfield		xx	Mortgage	\$17,720.00	05/01/02	\$ 2,800,000	\$ 2,748,409	05/1/07	variable	\$ 148,340	1		
2	Bank of Springfield		xx	Mortgage -- Loan fees							6,705	2		
3												3		
4												4		
5												5		
	Working Capital													
6	Central Office Allocation		xx	Working Capital								6		
7	Central Office Allocation		xx	Working Capital							386	7		
8												8		
9	TOTAL Facility Related					\$17,720.00		\$ 2,800,000	\$ 2,748,409			\$ 155,431	9	
	B. Non-Facility Related*													
10	Interest Income										(4,224)	10		
11												11		
12												12		
13												13		
14	TOTAL Non-Facility Related							\$				\$ (4,224)	14	
15	TOTALS (line 9+line14)							\$ 2,800,000	\$ 2,748,409			\$ 151,207	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Springfield COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0041699

CONTACT PERSON REGARDING THIS REPORT Craig Ater

TELEPHONE (309) 823-7135 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14280277027</u>	<u>Nursing Home</u>	\$ <u>107,312.00</u>	\$ <u>107,312.00</u>
2. <u> </u>	<u>Nursing Home</u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u><u>107,312.00</u></u>	\$ <u><u>107,312.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 33,800

B. General Construction Type:
 Exterior
 Brick/Wood
 Frame
 Number of Stories

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$ 630,000	1
2					2
3	TOTALS			\$ 630,000	3

Facility Name & ID Number Heritage Manor-Springfield

0041699

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	176	1963		\$ 1,870,000	\$		\$	\$
5		1966		1,648,258				
6		1999						
7								
8								
Improvement Type**								
9	1985 Improvements	1985		26,076				
10	1986 Improvements	1986		216,545				
11	1987 Improvements	1987		593,121				
12	1988 Improvements	1988		29,321				
13	1989 Improvements	1989		1,095				
14	1990 Improvements	1990		939				
15	1991 Improvements	1991		32,022				
16	1992 Improvements	1992		32,593				
17	1993 Improvements	1993		105,986				
18	1994 Improvements	1994		59,542				
19	1995 Improvements	1995		36,126				
20	Laundry Chute	1996		4,926				
21	Door Alarm	1996		8,533				
22	Garbage Disposal	1996		1,113				
23	Elevator	1996		11,439				
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	C/O Allocation						15,400	15,400
35	Book Depreciation				208,683		208,683	1,682,189
36								

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Vent Shaft	1997	\$ 6,267	\$		\$	\$	\$		37
38	Fire Dampers	1997	510							38
39	Computer Cabling	1997	14,518							39
40	Rehab Therapy Room	1997	7,391							40
41	Air Conditioner--Chiller	1997	47,954							41
42	Remodel First Floor	1997	27,570							42
43										43
44	Landscape	1998	2,410							44
45	Vent Work	1998	7,018							45
46	Asphalt Ramp	1998	850							46
47	Room Remodel	1998	1,142							47
48										48
49	Code Alert	1999	7,829							49
50	Wall Paper	1999	704							50
51	Remodel Office Interior	1999	1,248							51
52	Elevator Repair	1999	2,697							52
53	Carpet	1999	1,097							53
54										54
55	Shed Yardmate	2000	522							55
56	A/C Rooftop Unit	2000	2,937							56
57	Sewerline Repair	2000	1,482							57
58										58
59	Facility Renovation--Materials	2001	745,911							59
60	Facility Renovation--Labor	2001	1,463							60
61	Facility Renovation--Interior Design	2001	69,313							61
62	Fire Alarm System	2001	8,718							62
63	Sewer Line Repair	2001	1,787							63
64										64
65	Facility renovations: Paint , wallpaper, fixtures , floor coverings for all resident									65
66	rooms including hallways and common areas									66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 5,638,973	\$ 208,683		\$ 224,083	\$ 15,400	\$ 1,682,189		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,638,973	\$ 208,683		\$ 224,083	\$ 15,400	\$ 1,682,189	1
2	Landscape Design	2002	500						2
3	Freezer Compressor	2002	3,834						3
4	Smoke Detectors	2002	2,560						4
5	Facility Renovation--Materials	2002	186,172						5
6	Facility Renovation--Labor	2002	3,561						6
7	Facility Renovation--Interior Design	2002	15,497						7
8	Phone System	2002	2,064						8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,853,161	\$ 208,683		\$ 224,083	\$ 15,400	\$ 1,682,189	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,138,601	\$ 87,261	\$ 87,261	\$		\$ 905,709	71
72	Current Year Purchases	53,570						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,192,171	\$ 87,261	\$ 87,261	\$		\$ 905,709	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,675,332	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 295,944	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 311,344	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,400	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,587,898	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 23,512 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 236,884	\$		\$ 236,884	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			18,333			18,333	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			305,878	2,553		308,431	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescripts				722,065		722,065	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				23,191			23,191	13
14	TOTAL			\$		\$ 584,286	\$ 724,618		\$ 1,308,904	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 94,018	\$	1
2	Cash-Patient Deposits	15,741		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	926,503		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,352		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(24,377)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,050,237	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	630,000		13
14	Buildings, at Historical Cost	5,883,161		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,192,171		16
17	Accumulated Depreciation (book methods)	(2,587,898)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Tax Asset</u>	1,640,856		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,758,290	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,808,527	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 217,793	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,741		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	112,676		32
33	Accrued Interest Payable	8,735		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Security Deposits</u>	24,288		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 379,233	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,748,409		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,748,409	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,127,642	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,680,885	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,808,527	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,701,808	1
2	Restatements (describe):		2
3	<u>Audit Adjustment</u>		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,701,808	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,077	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (20,923)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,680,885	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,665,644	1
2	Discounts and Allowances for all Levels	(2,002,473)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,663,171	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,022,182	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,022,182	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,588	12
13	Barber and Beauty Care	5,750	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	974,684	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	50	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 985,072	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,224	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,224	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,674,649	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,265,949	31
32	Health Care	4,143,612	32
33	General Administration	1,656,153	33
	B. Capital Expense		
34	Ownership	561,445	34
	C. Ancillary Expense		
35	Special Cost Centers	965	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Debt Prepayment Penalty	17,448	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,645,572	40
41	Income before Income Taxes (line 30 minus line 40)**	29,077	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 29,077	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Springfield# 0041699Report Period Beginning: 1/01/2002Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,196	1,609	\$ 37,085	\$ 23.05	1
2	Assistant Director of Nursing	2,378	2,561	64,979	25.37	2
3	Registered Nurses	25,999	27,409	582,979	21.27	3
4	Licensed Practical Nurses	47,098	49,577	778,533	15.70	4
5	Nurse Aides & Orderlies	91,464	98,336	1,223,767	12.44	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,463	1,576	16,027	10.17	8
9	Activity Director					9
10	Activity Assistants	14,388	15,794	100,065	6.34	10
11	Social Service Workers	6,253	6,854	100,366	14.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,560	41,308	361,538	8.75	15
16	Dishwashers					16
17	Maintenance Workers	16,963	18,008	167,027	9.28	17
18	Housekeepers	16,779	18,284	154,336	8.44	18
19	Laundry	10,650	11,339	103,593	9.14	19
20	Administrator	2,080	2,080	69,064	33.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,977	17,861	272,508	15.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	291,248	312,596	\$ 4,031,867 *	\$ 12.90	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		16,900		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,134		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,650		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,684		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 3,191		50
51	Licensed Practical Nurses		9,380		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		\$ 12,571		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Heritage Manor-Springfield

STATE OF ILLINOIS

0041699

Report Period Beginning:

1/01/2002

Ending:

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12/31/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO no If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 96,360
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 9,206
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

GENERAL & ADMINIST WAGES	245,811	272,588
ADMINISTRATOR WAGES	49,864	49,864
VACATION & SICK - G&A	26,697	
EMPLOYEE BENEFITS	13,670	641,041
EMPLOYEE HEPATITIS VACCIN	3,185	
EMPLOYEE SCHOLARSHIP WA	2,589	
EMPLOYEE SCHOLARSHIP COS	1,922	
DIRECTORS FEES		
OFFICE SUPPLIES	29,551	29,551
TELEPHONE	36,820	36,820
TRAINING & EMPLOYEE DEVL	613	613
GENERAL TRAVEL	1,313	5,338
MEAL EXPENSE FOR TRAVEL	0	
EDUCATION & SEMINAR	4,243	
HELP WANTED ADVERTISING	4,299	120,465
PROMOTIONAL ADVERTISING	5,548	
PUBLIC RELATIONS	1,264	
LICENSES & FEES	96,788	
DUES & SUBSCRIPTIONS	12,042	
CONTRIBUTIONS	0	
PROFESSIONAL FEES	8,759	357,817
MEDICAL DIRECTOR	16,900	16,900
UTILIZATION REVIEW		
OTHER PHYSICIAN FEES		
MEDICAL RECORDS CONSULT	0	
PHARMACIST FEES	4,134	
SOC SERV/ACT CONSULT	1,650	1,650
TV RENTAL	-1,365	
INCOME TAXES		47,577
BACKGROUND CHECKS	504	
PAYROLL TAXES	524,444	
PAYROLL TAXES ADMINIST	7,169	
GROUP INSURANCE	242,507	
LIABILITY INSURANCE	75,099	75,099
INSURANCE-OWNERS	45,935	
WORKMENS COMP (INSURANCE)	149,078	
CENTRAL OFFICE FEES	47,577	
LOST ITEMS-RESIDENTS	0	
MISCELLANEOUS		
REAL ESTATE TAXES	110,338	110,338
LEASED EQUIPMENT	1,263	118
MAINTENANCE SALARIES	177,509	167,627
MAINTENANCE SICK & VAC	9,718	
ELECTRIC	62,839	135,041
NATURAL GAS	32,869	
HEATING & REFRIG. OIL		
WATER & SEWER	19,233	
TRASH COLLECTION	14,573	39,907
PROPERTY PLANT REPLACEME	2,889	62,642
GENERAL REPAIR & MAINT	40,633	
MAINTENANCE CONTRACTS	23,334	
DIETARY WAGES	335,409	361,538
DIETARY SICK & VAC	26,125	
SALES TAX		
FOOD PURCHASES	174,156	165,152
SUPPLIES-DISHWASHING	4,044	19,373
DIETARY REPLEACEMENT	1,609	
KITCHEN SUPPLIES-PAPER	11,620	
MEAL CREDIT	-9,266	
LAUNDRY WAGES	97,965	103,593
LAUNDRY SICK & VAC	6,568	
LAUNDRY REPLEACEMENT	14,140	25,633
LAUNDRY REIMBURSEMENT		
LAUNDRY SUPPLIES	11,493	
HOUSEKEEPING WAGES	136,247	154,336
HOUSEKEEPING SICK & VAC	18,089	
HOUSEKEEPING SUPPLIES	11,640	31,507
HOUSEKEEPING SUPPLIES-PPR	20,347	
RN WAGES-MEDICARE		2,765,370
RN WAGES-NON MEDICARE	533,245	
ADON WAGES	57,865	
ADON	64,979	
RN SICK & VACATION	49,734	
LPN WAGES-MEDICARE		
LPN WAGES-NON MEDICARE	740,568	
LPN WAGES OTHER	37,965	
LPN SICK & VACATION	37,965	
AIDE WAGES-MEDICARE		
AIDE WAGES-NON MEDICARE	1,143,981	
WARD CLERKS		
AIDE VACATION & SICK	79,786	
CONTRACT NURSES-INS	3,191	
CONTRACT NURSES-LPN	9,380	
CONTRACT NURSES-AIDES	0	
NURSE AID TRAINING WAGE	0	0
NURSE AID TRAINING EXP	0	0
NURSE AID TRAINING REIMB	0	
REHAB WAGES	14,884	
REHAB SICK & VAC	1,143	
NURSING DEPT EDUCATION		
NURSING SUPPLIES	177,227	175,562
NURSING SUPPLIES	36,544	
REPLACEMENT-NURSING	2,151	
NURSING OTHER	5,947	20,652
DRUG PURCHASES	354,132	568,479
DRUG PURCHASES-OTHER	252,294	
LABORATORY SERVICES	23,191	450,289
HOME HEALTH SALARY		
HOME HEALTH SICK & VAC		
HOME HEALTH EXPENSES		
ACTIVITIES WAGES	90,116	100,065
ACTIVITIES SICK & VAC	3,949	
ACTIVITIES SUPPLIES	5,879	5,879
ACTIVITIES FEES	0	0
PT WAGES		
PT SICK & VACATION		
PT FEES	246,759	
PT SUPPLIES	2,153	
SOCIAL SERVICE WAGES	93,471	100,366
SOCIAL SERVICE SICK & VAC	6,895	
SOCIAL SERVICE EXPENSES	0	0
OT FEE	109,060	
SOCIAL THERAPIST FEE	0	0
STRETCH THERAPY FEE	11,299	0
BEAUTICIAN WAGES		
BEAUTICIAN SICK & VAC	889	889
BEAUTICIAN FEES		
BEAUTY SHOP SUPPLIES	76	76
VOLUNTEER COORDINATOR		
VOL COORD SICK & VAC	0	
VOL COORD SUPPLIES		
RENT		0
INTEREST EXPENSE	148,540	155,045
DEPRECIATION	295,544	295,544
LOAN FEE AMORTIZATION	6,765	
INTEREST INCOME	-4,224	
MISC NON-OPERATING INCOM	0	
INCOME TAXES	17,448	
	7,641,540	7,628,124
	-29,877	-13,238